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Suaahara Health Services Promotion Framework and Plan

Submitted to:

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SUAAHARA

Building Strong & Smart Families

Save the Children · Helen Keller International · Jhpiego · Johns Hopkins Bloomberg School of Public Health · Center for Communication Programs

Health Services Promotion Framework and Plan

Over the past decade, many women and children in Nepal have become healthier due to initiatives led by the Ministry of Health and Population (MoHP). According to the Nepal Demographic and Health Survey (NDHS), in the 10 years the number of women dying during pregnancy or within 42 days of the end of pregnancy has been cut in half (539 deaths per 100,000 live births in 1996 to 281 in 2006—based on the most recent available data). The total fertility rate has also declined from an average of 4.1 births to 2.6 births per woman. Likewise, infant and under-5 mortality have dropped a lot. This means fewer pregnancies, fewer but healthier children and smaller families. When families space births, children are more likely to survive. For example, if the birth-to-pregnancy interval is less than 18 months, less than half of children survive and are well nourished. When families increase spacing to 24 months and 36 months, more children survive and enjoy good nutrition(55% and 63% respectively) (USAID, 2012).

Even though these improvementsare encouraging, not all women and children in Nepal are well nourished and healthy. 4 out of every 10 children below the age of 5 are stunted (malnourished over a long time period), and 3 out of every 10 are underweight (their weight is low for their age).There are a number of reasons why this is so including inadequate access, availability and quality of health services. According to the 2011 NDHS, 1 in 3 women and 5 in 10 children are anemic. Information from Suaahara's baseline suggests that anemia among women is even higher (4 in 10 women are anemic) and that anemia is really a problem among pregnant women (more than 6 in 10 women from Suaahara's baseline are anemic) and in the Terai where nearly 6 in 10 non-pregnant women suffer from anemia. Even so, most women take iron tablets (80% according to the NDHS) and more than half (55%) take treatment for intestinal parasites during their most recent pregnancy. Per Suaahara's baseline, while most women (86.5%) receive at least some iron/folic acid tablets), only 38.0% receive the full course (180 days). 70.3% of women participating in Suaahara's baseline took de-worming tablets during pregnancy. Suaahara will encourage women to get iron tablets and anti-helminthic drugs free of charge as part of the government's health services.

Sadly, neonatal mortality has not changed in the past 5 years. One challenge is the small size of newborns: 1 of every 15 babies in Nepal is born small (NDHS, 2011). The MoHP has developed a community-based newborn care package (CB-NCP) to address newborn health and by 2012, had rapidly scaled it up to 34of Nepal's 75 districts.

Breastfeeding is an important component of CB-NCP and is critical to improving the nutritional status of infants and children. But only 45% and 39.1% of Nepali infants are breastfed in the first hour of life according to the NDHS and Suaahara's baseline, respectively). The 2011 NDHS reports that 70% of Nepali children less than 6 months of age are breastfed exclusively.However, findings from Suaahara's baseline show that exclusive breastfeeding is much lower (46% in program areas and 53% in comparison areas). This means that Suaahara will need to focus a lot of attention on exclusive breastfeeding.

Malnutrition also affects women: 18% of women in Nepal and 22.9% of women from Suaahara's baseline are chronically energy deficient with a body mass index of less than 18.5 (NDHS 2011, Suaahara's baseline).According to the further analysis of the 2011 NDHS, maternal undernutrition in

Nepal has significantly decreased over the past 15 years; however a worsening trend was found in mountainous districts (Crum et al, 2012). Since 1996, the Terai has seen the biggest reductions in maternal undernutrition; however, women in the Terai still suffer from the highest prevalence of chronic energy deficiency, as measured by BMI (27%) (Crum et al, 2012).

Although the age at first marriage has increased significantly in the past 15 years (NDHS 2011), women in Nepal still marry when they are young. More than half (55%) of women age 25-49 marry by age 18 (NDHS 2011) and 1 in 5 marry by age 15. Families often expect women to have a child soon after getting married. Almost half (48%) of all first births in Nepal happen before women are 20 years old. For adolescent women (an underserved population), Suaahara will promote healthy timing and spacing of pregnancies (HTSP) to delay first pregnancy and to encourage them to get routine antenatal care (ANC), childbirth, postpartum/postnatal care and immunizations.

The Ministry of Health and Population (MoHP) is committed to improving the health and nutrition of women, newborns and children by 2015. In 2004, the Government of Nepal (GoN) developed the National Nutrition Policy and Strategy, followed by a Three Year Plan beginning in 2010. The GoN has also developed a Second Long-Term Health Plan (SLTHP) through 2017 as well as the Nepal Health Sector Program-Implementation Plan 2 (NHSP-IP II). In 2011, the GoN approved the Multi-Sectoral Nutrition Plan (MSNP 2011-2015), which recognizes the importance of ministries other than health in improving nutrition. This plan focuses on the 1000 day period between conception and 24 months of age. As part of a Nutrition Technical Committee (NUTECH), the government and external development partners has recently (2013) drafted the Health Strategy for Addressing Maternal Undernutrition. That strategy calls for the acceleration of reductions in chronic undernutrition and micronutrient deficiencies in adolescent girls, pregnant women and breastfeeding mothers, particularly among disadvantaged and vulnerable groups. The strategy sets goals for reducing chronic energy deficiency, anemia and vitamin A and iodine deficiencies.

This strategy will use five approaches to reducing maternal undernutrition:

1. Enhance the capacity of the government to design, implement and evaluate programs at central, regional and district levels
2. Integrate maternal nutrition into key health programs, including community based approaches
3. Improve knowledge regarding maternal nutrition, including diet and care practices, through advocacy, community mobilization and behavior change communications.
4. Involve appropriate non-health sectors in maternal nutrition services, and
5. Strengthen knowledge and contribute information on best practices for evidence-based planning, implementation and monitoring for effective maternal nutrition programming

We've learned the following about health and nutrition programs that aim to improve the health of women and children:

- When cost is not a barrier to using maternal health services, many more women get antenatal care and deliver in healthcare institutions, even marginalized and disadvantaged women. Access is still not equitable but improving.
- Because more pregnant women have regular contact with health services, there are more opportunities to educate and counsel them about their own nutrition and health as well as the nutrition and health of their babies.
- Health care providers are busy with little time for counseling. Family planning and nutrition counseling and services need to be integrated to allow providers and clients the opportunity to counsel, learn and try new behaviors.
- Despite improvements, most women deliver at home without skilled care and a majority of their newborns do not receive a postnatal care visit within 2 days of birth. There is much we can do to promote access to high quality health services at these critical times.

- Less than 1 in 10 Nepali women receive any family planning information or counseling shortly after birth (NDHS 2011). Women need counseling and services from multiple sources—including Female Community Health Volunteers (FCHVs), mothers' groups and health care providers.
- The MoHP has successfully implemented a number of community-based health programs that address major causes of illness. Community-based Integrated Management of Childhood Illness (CB-IMCI) is an example of an established program where nutrition can be integrated.
- Training alone does not usually improve the quality of health services. Health care providers also need support supervision, a functional health facility and enabling environment to change and sustain the quality of care they provide. Community engagement through processes such as Partnership Defined Quality (PDQ) and health facility operations and management committees (HFOMCs) help improve infrastructure, resources and communication.
- PDQ and other approaches have been used to improve dialogue between communities and health service providers. While these approaches need to be facilitated and require a great deal of time, so far they have sustainably improved health services.
- HFOMCs are innovative and have been used successfully in some areas of Nepal. They can mobilize resources and build self-efficacy in a sustainable fashion.
- Infection prevention and control is a core component of health services strengthening, yet not all health facilities have water. Water, Sanitation and Hygiene (WASH)activities within health facilities can be integrated into infection prevention and control activities and supported by HFOMCs.

Because the government is already providing maternal, newborn and child health and nutrition (MNCH-N) services, Suaahara will focus its efforts on working with the Department of Health Services (DoHS) of the MoHPto:

- Strengthen the integration of nutrition into these services at all levels;
- Improve the quality of MNCH-N services; and
- Provide HTSP counseling and services.

Suaahara will work in all village development committees (VDCs) in each of its20 districts to ensure pregnant and postpartum women and children less than two years of agehave access to quality MNCH-N information, counseling and services.

Objectives

1. Support health care providers to give quality counseling on MNCH-N.
2. Improve the quality of MNCH-N servicesby working in partnership with health facility staff and the community.
3. Increase access toMNCH-N services among excluded communities.
4. Improve HTSP with a special focus on marginalized, unreached women.

Strategies

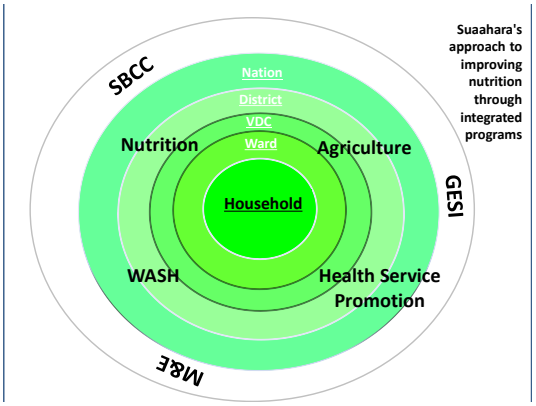
To achieve these objectives, Suaahara has developed a number of health services strategies for year 2 and 3 that link with other Suaahara activities (such as ENA+) and also address major challenges (See **Table 1**) families currently face as they access services.

Table 1. Suaahara Health Promotion Objectives and Strategies		
Objectives	**Issues/Challenges**	**Strategies**
1. Support health care providers to give quality counseling on MNCH-N.	• Nutrition information, counseling and other services are not fully integrated in MNCH guidelines, training and materials	Help the MOHP review, integrate and revise existing guidelines, protocols, strategies, training curricula and materials to make sure that the nutrition content is correct, targeted and effective.
	• Health care providers get very little training on nutrition or counseling skills while in school or during in-service trainings • Families often go to the private sector to get care for sick children. Pharmacists and others are generally not up-to-date on CB-IMCI or are not able to provide nutrition counseling.	Help health care providers and private practitioners better integrate nutrition counseling into child health services.
2. Improve the quality of MNCH-N services by working in partnership with health facility staff and the community.	• Discussions between communities and health facility staff either do not happen or are not always productive • Health care providers do not always understand community needs. • Health care providers are often unaware of how gender and social exclusion compromise health-seeking and access to care. • It is difficult to sustain quality services in rural or remote areas. • HFOMCs are not fully functional at all health facilities. • HFOMCs require technical guidance if they are to focus on improving programs, especially for disadvantaged groups and women.	Use PDQ to strengthen communication between health care providers/health facilities and the community and to strengthen HFOMCs to improve the quality of MNCH-N services.
3. Increase access to MNCH-N services among excluded communities.	• Public health center/outreach clinics (PHC/ORCs) are the main mechanism to deliver MNCH-N services to communities farthest away from health facilities but are not always able to regularly provide services to the groups that are most in need.	Reactivate and strengthen PHC/ORCs in hard- to- reach, remote areas and among disadvantaged groups (DAGs) to improve nutrition counseling.
4. Improve healthy timing and spacing of pregnancy with a special focus on marginalized, unreached women	• Women and healthcare providers are not generally aware of postpartum family planning and HTSP	Develop HTSP materials and train healthcare providers for effective counseling.
	• Both HTSP and nutrition are not well-integrated into existing MNCH services.	Use Quality Improvement tools and approaches to strengthen MNCH-N services (including HTSP and family planning).

Suaahara will work in households, wards, VDCs, districts and nationally. **Figure 1**describes what we will do.

Figure 1. Suaahara Health Services Promotion at All Levels

LEVEL	ACTIVITIES
Household	• Help families provide pregnant women one extra meal a day and breastfeeding mothers two extra meals using peer educators, social mobilizers, FCHVs, and healthcare workers. • When providing services at the clinic, model and demonstrate correct handwashing. Give a message or two to families so that they too adopt these practices. • Help families practice HTSP of pregnancies.
Ward	• Establish training and capacity building of health care workers on nutrition counseling, CB-IMCI and HTSP, within existing MNCH services.
VDC	• Help service providers improve counseling on four priority actions during every contact point. • Establish links between health facilities and communities using PDQ and MNCH-N quality improvement tools. • Using an expanded PDQ model, increase access and use of facility-based services for disadvantaged groups.
District	• Coordinate with DHO/DPHO to roll out training regarding nutrition, care of the sick child and HTSP.
Nation	• More fully integrate nutrition into existing guidelines, protocols, strategies and training materials, as needed.

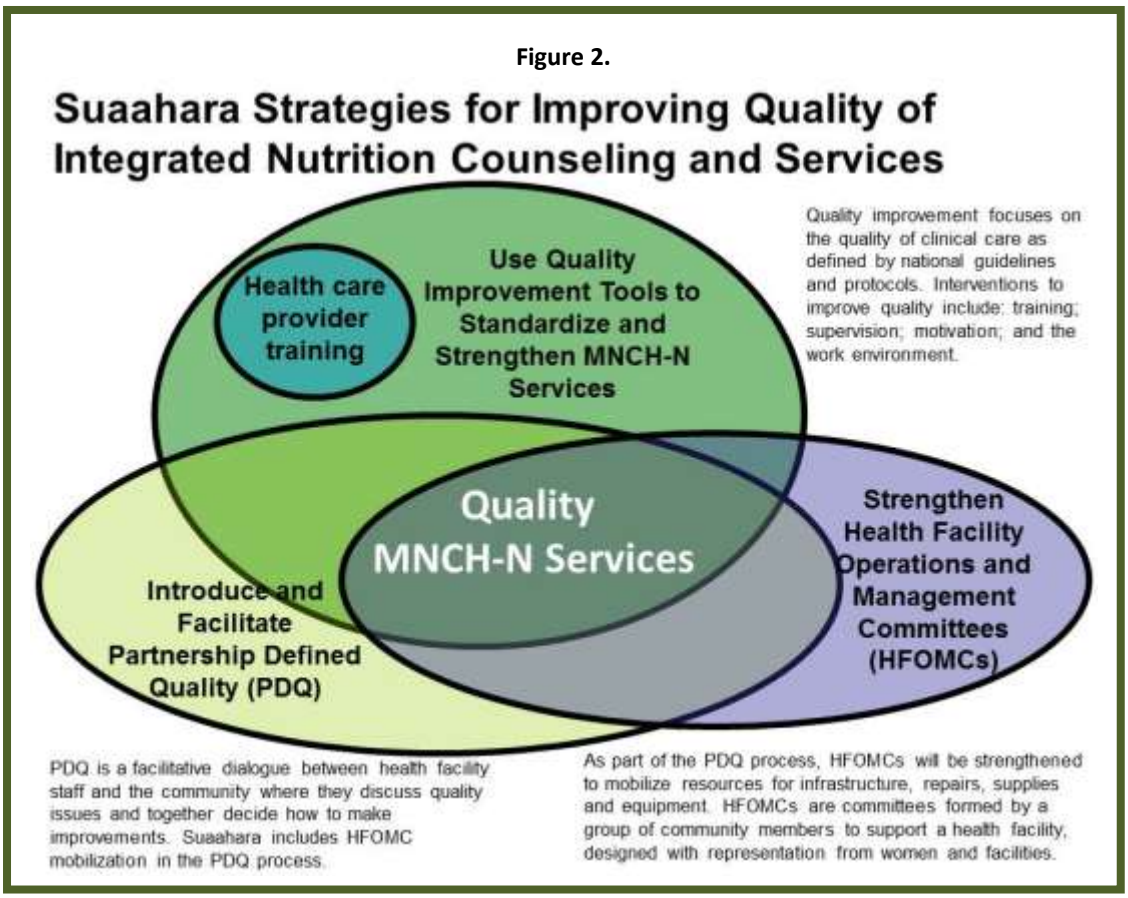


In year 2, Suaahara will focus on 5 practices that have been shown to reduce malnutrition:

1. Train healthcare providers, pharmacists, families and other individuals to help mothers give an extra meal to pregnant women and two extra meals to those who breastfeed
2. Encourage families to add three things to the baby's diet: 1) animal source food such as eggs and meat 2) greens, and 3) orange-fleshed foods
3. Work with caregivers so that they wash their hands before feeding the baby, and
4. When baby is sick, continue to breastfeed and give extra food. After baby is better, give an extra meal each day for 2 weeks.
5. Help families use floor mats and chicken coops to create physical barriers between children and animals, particularly animal feces.

The major strategies Suaahara will use for health services promotion in year 2 are described below. Figure 1 depicts how Suaahara's integrated strategies will improve the quality of MNCH-N services in project districts.

Figure 2.



Here is an example of how these activities will help improve the quality of nutrition counseling and services and promote the key practices described above. Suaahara will encourage healthcare providers to wash their hands before every checkup, especially before interacting with newborns and children to demonstrate to caregivers the importance of washing their hands. However, many health facilities in Nepal lack running water. Quality improvement tools can be used to determine if a health facility has soap and water, and it is also possible that the community through PDQ would identify not having water as a problem. To address this issue, the HFOMCs purchase buckets with taps, fix broken pipes or find a local source of water for the facility.

1. ***Helpthe MOHP review, integrate and revise existing guidelines, protocols, strategies, training curricula and materials to make sure that the nutrition content is correct, targeted and effective.***

Working closely with FHD, CHD, MD, PHC/ORC Revitalization and the National health Training Center (NHTC), Suaahara will facilitate the review of maternal, newborn and child health-related policies, strategies and training curricula. Where nutrition content can be better integrated, Suaahara will support revision. For example, if in existing in-service training curricula, HTSP or nutrition content is not as detailed or well-integrated as it should be, this content will be added. This process begins in year 2 but will likely continue through year 5 as each national review process (such as National Medical Standards, CB IMCI, the community-based newborn care package [CB-NCP] or the skilled birth attendants [SBA] training curricula reviews) occurs. As needed, related materials such as job aids will be identified for revision to ensure consistency.

2. Help health care providers and private practitioners better integrate nutrition counseling into child health services.

Community Based Integrated Management of Childhood Illness (CB-IMCI) Program is an integrated package of child survival interventions and addresses major childhood killer diseases like Pneumonia, Diarrhea, Malaria, Measles, and Malnutrition in 2 months to 5 year children in a holistic way. With the implementation of this package children are diagnosed early and treated appropriately for major childhood diseases at the health facility and community level. At the community level FCHVs are the main vehicle of service delivery and also plays key role to increase community participation.

Working closely with CHD, in year 2, Suaahara will focus on strengthening the nutrition component of the CB-IMCI national training course. Suaahara will help CHD fieldtest a revised CB-IMCI package in one district to demonstrate its feasibility. Based on results, Suaahara will work with CHD to roll it out in other Suaahara districts in years 3–5.

Because families often seek care for sick children from the private sector, Suaahara will strengthen private practitioners' (mainly pharmacists') skills on CB-IMCI and nutrition, beginning in Year 3. Working closely with CHD, in one district we will conduct an assessment of pharmacists' knowledge,skills and attitudes on CB-IMCI. Based on findings, we will develop a strategy to build the capacity of private practitionersthat includes training.After that, we will develop a training package then field test it in one Suaaharadistrict.Thefieldtest findings will be shared, and the CB-IMCI package will be revised then rolled out in other districts.

3. Use PDQ to strengthen communication between health care providers/health facilities and the community.

To strengthen the maternal newborn child health and nutrition (MNCH and N) service in local health facility, health facility operation management committee (HFOMC) necessary to equip to take more responsibility and be capable of managing health facilities in a participatory, accountable and transparent way so that health status in the community is improved, particularly among the marginalized community. So Partnership Defined Quality (PDQ) is a methodology developed and used by Save the Children to improve the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process. PDQ creates an interaction between healthcare providers and communities to focus on health issues that most affect the community, empower communities and increase the equitable use of service. To implement this Suaahara in coordination with NHTC will develop training manual at NHTC standards and finalized after the field testing in one of the Suaahara district. In year 2, Suaahara will introduce and use PDQ beginning in 12 districts. After modifying some of the existing materials and conducting the M-TOT, we will conduct district-level trainings on PDQ for staff from Suaahara, local NGOs and the DHO/DPHO. Suaahara will then implement PDQ in select low performing health facilities at the VDC level.

HFOMC members will be engaged in PDQ to better address some of the needs identified by PDQ. For example, the VDC Council meets 3 times a year and can support PDQ activities. Technical supervision to these PDQ health facilities will be conducted quarterly by HFOMC members.

4. **Strengthen HFOMCs to improve the quality of MNCH-N services at HF**

The responsibility of the management and operation of the health institution has been transferred to the local health facility management and operation committee (HFOMC). Suaahara incoordination with NHTC focus to build the capacity of HFOMCs by providing those related skills and knowledge

for the effective management and operation of the health institutions to strengthen and provide quality of services on maternal newborn child health and nutrition (MNCH and N) as well as family planning through community engagement process of PDQ.

To support MoHP decentralization of health service management to local bodies, Suaahara will encourage local communities to take greater responsibility in managing local health facilities and health programs through Health Facility Operation and Management Committees (HFOMCs).

In Year 2, Suaahara strengthen HFOMC activities with PDQ. In the same 12 districts, we will conduct orientation for Suaahara and local NGO and DHO/DPHO staff and for health facility management committees (HFOMCs) during PDQ implementation process.

At the VDC level, Suaahara will roll out a program for strengthening HFOMCs. This strengthening is intended for HFOMCs and QI team members. It is expected that the HFOMCs will understand their roles and responsibility and they will be capable to discuss DDC/VDC and ward citizen forum for resources generation. It is expected that HFOMC in coordination DHO/DDC/VDC provide essential equipment, materials and supplies as identified when using MNCH-N QI tools and PDQ process implementation to improved nutrition-related services at health facilities and at PHC/ORCs.

Suaahara will facilitate to organize follow-up/ or review meeting after 6 and 12 months PDQ implementation . To monitor the progress and the functional status Of HFOMC quarterly joint supervision visits will be conducted by the DHO/DDC. In Year 3 these HFOMC activities will be rolled out to the 8 remaining Suaahara districts. Suaahara facilitate to build the linkages between HFOMC, HF staff, VDC and ward citizen forum to generate the resources.

5. Reactivate and strengthen PHC/ORCs in hard- to- reach, remote areas and among disadvantaged groups (DAGs)to improve nutrition counseling.

FHD has prioritized revitalizing PHCs/ORCs and Suaahara will support this process in its districts. Because PHCs/ORCs are designed to reach the most marginalized communities, Suaahara will first work with FHD and district health (Public) offices (D/PHOs) to map existing PHCs/ORCs and identify those where improvements are possible. After D/PHOs develop a joint plan to improve coverage and quality in selected Suaahara districts, Suaahara will support reactivation of PHCs/ORCs where needed, beginning with orientations to the HFOMC or PHC/ORC management committee as well as interaction will be carry out with social leaders, teachers, influential person in the presence of FCHVs basically on service utilization form ORC at the VDC level in year 2. Under the leadership FHD orientation and interaction guideline will be developed and this will be used in Suaahara district. This activity will be linked with HFOMC activities. Technical supervision visits will be conducted semi-annually by DHO/DPHO and Suaahara staff to strengthen outreach services.

6. Develop HTSP materials and orienthealthcare providers for effective counseling at health facilities.

Because HTSP is an important strategy to promote maternal and child health and nutrition, Suaahara will focus on HTSP orientation for health care providers in year 2. Working closely with FHD, we will develop orientation materials to strengthen facility-based and community health services on HTSP/FP and its potential impact on MNCH-N. In the materials development process, we will build on HTSP and postpartum family planning activities previously conducted in Nepal by collecting and reviewing existing materials related to HTSP. Under the leadership of FHD, the 3-day orientation package on HTSP with a focus on nutrition will be developed. It will be translated into Nepali and HTSP job aids will also be developed.

Under the leadership of FHD (central level), Suaahara will conduct an M-TOT on HTSPto develop master trainers. In year 2, Suaahara will roll out orientation in 9 Suaahara districts to orient all health care providers, based on district planning and a DTOT at the district level. In year 3, Suaahara will roll out the HTSP orientation in the remaining 11 districts.

7. Use Quality Improvement tools and approaches to strengthen MNCH-N services (including HTSP and family planning).

There are various quality improvement approaches that have been used successfully in Nepal. These are designed to define quality and support health facility staff to make improvements in services. In year 2, Suaahara will build on the use of Quality Improvement tools and link them to PDQ as a pilot in Dolakha district. The objective of this pilot is to explore whether MNCH-N QI tools and PDQ are effective at improving the quality of MNCH-N services (including HTSP and nutrition) at health facilities.
A set of QI Tools for MNCH-N Services wasdeveloped in 2012 in close coordination with CHD and FHD. Based on stakeholder input, the QI tools will be revised and printed for the fieldtest. At the district level, Suaahara will introduce and orient 15 of 54 health facilities in Dolakha in the use of QI tools, and then help them conduct baseline assessments and develop action plans for making improvements. Based on gaps identified through the use of QI and linked with the PDQ, the D/PHO and HFOMCs will support improvements at these health facilities. For example, the QI tools have integrated nutrition and HTSP into ANC and PNC standards, but healthcare providers may not have been trained on this content in previous preservice or in-service trainings. By helping providers assess MNCH-N services at their facility, they will identify ways to improve nutrition counseling and to also offer HTSP services. Every six months, Suaahara staff will use MNCH-N QI tools to conduct technical supervision of health care providers. Suaahara willthen conduct a follow-up workshop for all facilities to assess and compare progress to date. Results from the pilot and lessons learned will be shared with CHD and FHD in year 3. Based on findings, Suaahara will support expansion into other project districts in years 3–5.

In all project districts, Suaahara will participate in and support district-level planning and coordination, for example, by providing assistance toreproductive health coordinating committees (RHCC) and at district review meetings.

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